PACIFIC EYE INSTITUTE

Welcome to Pacific Eye Institute

New Patient Information

Date _____

Patient First Name _____Last Name _____

Date of Birth _____ Email _____

Marital Status:____ Married ____ Single ____ Widowed ____ Divorced

_____ Separated _____ Partner _____ Unknown

Gender: ____ Male ____ Female _____ Unknown

Mailing Address_____

City _____State _____ Zip Code _____

Home Phone ( ) _____ - _____ Mobile Phone ( ) _____ - _____

Work Number Phone ( ) _____ - _____

Preferred phone: Home / Mobile / Work

Occupation _____Employed by_____

Do you have a Power of Attorney? Yes / No *If yes, please provide a copy.*

Do you have an advanced directive? Yes / No

Spouse or Parent/Guardian/Conservator Information

Name _____

Date of Birth _____ Relationship _____

Phone ( ) _____ - _____

Employed by _____ Occupation _____

Insurance Information

Please check coverage and supply requested information

- No Insurance
- Medicare ID# _____
- Medi-cal ID# _____
- Other Insurance – Carrier name _____

Policy Number and Effective Date_____

Subscriber information

- **Patient**
- **Other** (if other please fill in below)

Name _____Relationship _____

Date of Birth _____

Emergency contact (not at same address)

Name _____ Relationship _____

Address _____

Phone ( ) _____ - _____

My Physicians

Primary care Physician _____

Additional Physician _____

Optometrist _____

Whom may we thank for your referral?

- Physician _____
- Yellow Pages
- Other _____

Requested by State of California

RACE	**ETHNICITY**	**PRIMARY LANGUAGE**
C - Caucasian B - Black/African American H - Hispanic A – Asian G – Native American F – Asian Pacific American P – Pacific Islander D - Subcontinent Asian American I – American Indian/Alaska Native J – Native Hawaiian M – Multi Race N – Black Non Hispanic O – White Non Hispanic E – Other Race or Ethnicity M – More than One Race N1 – Refuse to state N2 – Race not known N3 – Not Ascertained	L – Latino/Hispanic X – Not Hispanic or Latino O – Other N – Not reported/Refuse U - Unkown ☐☐	_____ _____

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Patient Name _____ Date of Birth _____